BEST RECOVERY HEALTH CARE, INC.

1708 N. Laurent St., Victoria, Texas 77901
Phone: 36-572-9122 Fax: 361-572-8607

James Hebert
Executive Director/Sponsor

Natalie Carroll, M.D.
Medical Director

MEDICATION RECORDS

Medication taken to VCJ Infirmary

ONE (1) DOSE/BOTTLE OF MEDICATION TO BE ADMINISTERED DAILY.

Number of doses/bottles delivered: 9

NOTE: Each bottle contains See below mgs of METHADONE Hydrochloride.
Methadone hydrochloride is a scheduled II controlled substance under the Federal Controlled Substance Act. Appropriate accountability and security measures are required.

Date	Name		Time	Date	Signature of physician or nurse
9/18/18	Harrington, Clint	90mg	0900		
9/19/18	Harrington, Clint	80mg	0900		
9/20/18	Harrington, Clint	70mg	0900		
9/21/18	Harrington, Clint	60mg	0900		
9/22/18	Harrington, Clint	50mg	0900		
9/23/18	Harrington, Clint	40mg	0900		
9/24/18	Harrington, Clint	30mg	0900		

Total Doses/ Bottles 9

9/18/18 Tammy Player, LVN Nancy Ellis LVN
Date Delivered By Received By

Medication should be administered on the dates indicated above. Medication not administered in accordance with the above schedule must be returned to Best Recovery Health Care, Inc., Attn: Nurse (361) 572-9122.

Revised: December 2016

4826

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Date	Name	Time	Date	Signature of physician or nurse
9/25/18	Harrington, Clint 20mg	0900		
9/26/18	Harrington, Clint 10mg	0900		

Total Doses/ Bottles 9

9/18/18 Date — Tammy Player, LVN Delivered By — Nancy Ellis LVN Received By

Medication should be administered on the dates indicated above. Medication not administered in accordance with the above schedule must be returned to Best Recovery Health Care, Inc., Attn: Nurse (361) 572-9122.

Revised: December 2016

Family Name HARRINGTON First CLINTON Patient No. Room

9-9-18

INDIVIDUAL NARCOTIC RECORD

Name of Drug: METHADONE 100mg RX No. # 1 1/2

Ordered by Physician: Dr L. Carroll

Date Received/ Signature

Quantity Rcvd

	Date	Time	Dose	Oral or Other	Adm. By Nurse - Signature	Amount Remaining	Balance Checked by	Balance Checked by	Date	Balance Counted
30										
29										
28										
27										
26										
25										
24										
23										
22										
21										
20										
19										
18										
17										
16										
15										
14										
13										
12										
11										
10										
9										
8										
7										
6										
5										
4										
3										
2										
1										

Remove this Receipt Before Attempting to Seal Bag. Retain for Records.

Case#: HARRINGTON, CLINTON

Date: 7/24/86

Prepared By: 6597550

DISPOSITION OF UNUSED DRUG

Date of Discontinuance _____ Amount Remaining _____

Disposition _____

Date of Disposition _____ X _____ X _____

Authorized Signature | Witness Signature

1-2014

CONTROLLED SUBSTANCE PERPETUAL INVENTORY / USAGE RECORD

Inmate Name / Floorstock: Harrington. Clint

ID #: _____ RX #: _____

Physician: Best Recovery

Medication: Methadone

Strength: 100 mg

Directions: Take 1 dose ± H_2O QD

OR AFFIX LABEL FROM BLISTER CARD IN THIS SECTION

Date Received / Transferred: 9/11/18

Amount Received / Transferred:

Received / Transferred from:

Received by: Katrina Larson

Witnessed by:

All spaces must be completed for each dose given.

All records must be legible and accurately completed..

Two persons must witness receipt, transfer, waste or destruction of controlled substances.

* Must be completed if waste occurs.

Date	Time	Patient Last Name, First Name	ID#	Provider	# On Hand	Dose Given	* Doses Wasted	Balance	Administered By Signature	* Waste Witness Signature
9/11	10A	Harrington, Clint		Metzger	7	1		6	Kat	
9/12	8	Harrington Clint		Metzger	6	1		5	K. Ellis LVN	
9/13	8	Harrington		Metzger	5	1		4	K. Ellis LVN	
9/14	10A	"		"	4	1		3	Kat	
9/15	10A	"		"	3	1		2	Kat	
9/16	10A	"		"	2	1		1	Kat	

Medication removed from count in the following manner: (circle one)

Destroyed Sent out for destruction Personal Property / Returned to Inmate

Quantity destroyed / sent out / returned: _____

Date: _____ Time: _____

Nurse verification: _____

Witness verification: _____

Pharmacist signature: (required for destruction): _____

Medication transferred to another book or page: (update index page)

Book: _____ Page: _____

Quantity transferred: _____

Date: _____ Time: _____

Nurse verification: _____

Witness verification: _____

CONTROLLED SUBSTANCE PERPETUAL INVENTORY / USAGE RECORD

Inmate Name / Floorstock: Harrington Clint

ID #: _____ RX #: _____

Physician: Best Recovery

Medication: Methadone

Strength: _____

Directions: Taper dose

OR AFFIX LABEL FROM BLISTER CARD IN THIS SECTION

Date Received / Transferred: 9/18/18

Amount Received / Transferred:

Received / Transferred from:

Received by: N. Ellis LVN / [signature]

Witnessed by: [signature]

All spaces must be completed for each dose given.

All records must be legible and accurately completed.

Two persons must witness receipt, transfer, waste or destruction of controlled substances.

* Must be completed if waste occurs.

Date	Time	Patient Last Name, First Name	Bottle ID#	Provider	# On Hand	Dose Given	* Doses Wasted	Balance	Administered By Signature	* Waste Witness Signature
9-18		90 mg	# 1			90mg			N. Ellis LVN	
9-19		80 mg	# 2			80mg			[signature]	
9-20		70 mg	# 3			70			[signature]	
9-21	6100	60 mg	# 4			60mg			N. Ellis LVN	
9-22		50 mg	# 5			50mg			N. Ellis LVN	
9-23		40 mg	# 6			40mg			N. Ellis LVN	
9-24		30 mg	# 7			30mg			[signature]	
9-25		20 mg	# 8			20mg			[signature]	
9-26		10 mg	# 9			10mg			N. Ellis LVN	
		then D/C	D/C							

Medication removed from count in the following manner: (circle one)

Destroyed Sent out for destruction Personal Property / Returned to Inmate

Quantity destroyed / sent out / returned: _____

Date: _____ Time: _____

Nurse verification: _____

Witness verification: _____

Pharmacist signature: (required for destruction): _____

Medication transferred to another book or page: (update index page)

Book: _____ Page: _____

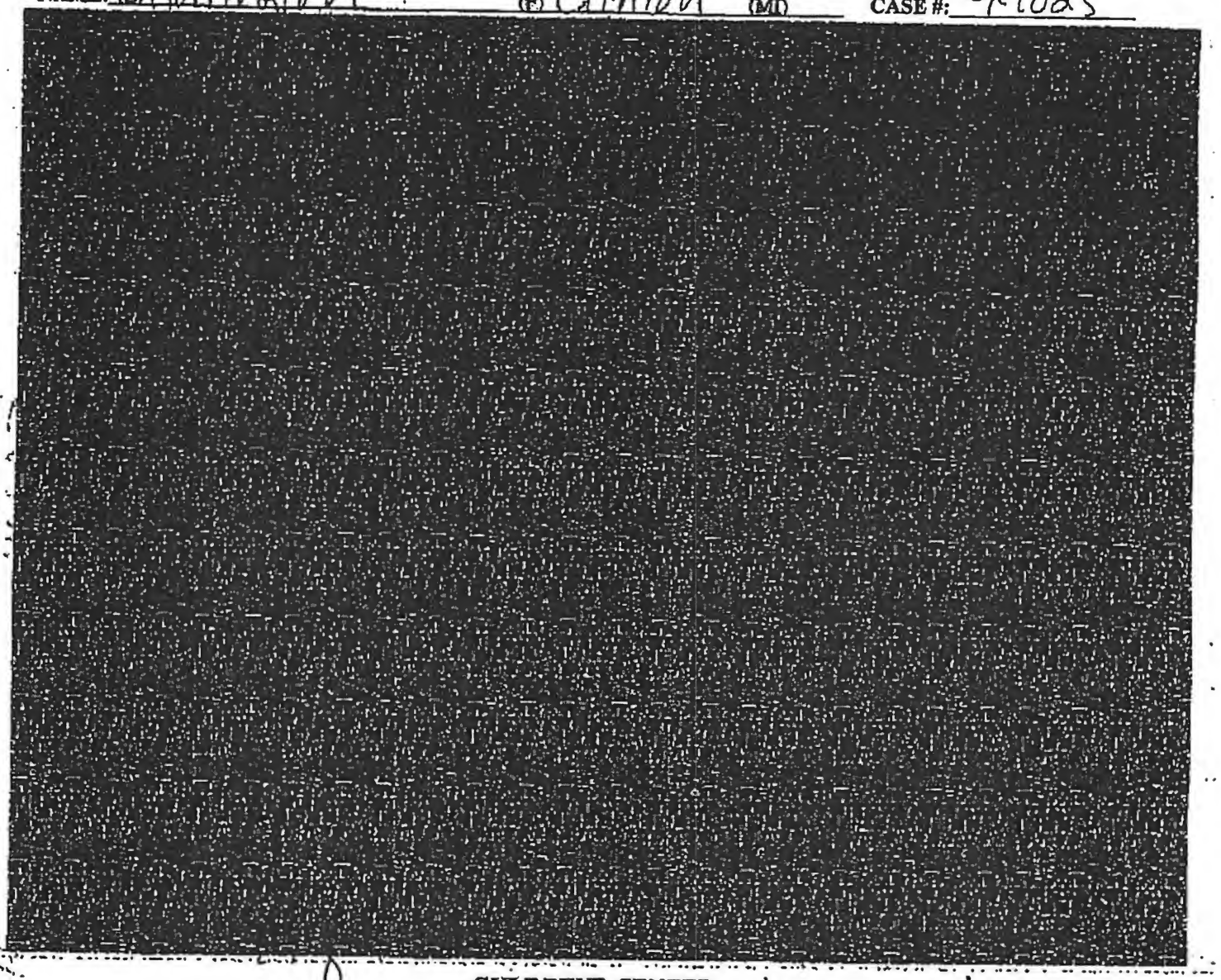
Quantity transferred: _____

Date: _____ Time: _____

Nurse verification: _____

Witness verification: _____

NAME: [redacted] CASE #: [redacted]



GULF BEND CENTER
6502 Nursery Drive, Victoria, TX 77904 (361) 575-0611

James Dotter, M.D.
DEA#: BD6535148
TX Lic#: J6408 DPS#: 50113144

Angela Covarrubias, PMHNP
TX Lic#: AP132033 RX #: 21426
Supervising Physician: James Dotter, M.D.

NAME: Clinton Hannyton DOB: 7.24.66 DATE: 5.8.18

ADDRESS: PHONE #:

Rx

1. Abilify 5mg; 1PO QAM X30 Refills 1 2 (3) 4 No Refills
2. prozac 40mg; 2 PO QAM X60 Refills 1 2 (3) 4 No Refills
3. Refills 1 2 3 4 No Refills
4. Refills 1 2 3 4 No Refills
5. Refills 1 2 3 4 No Refills

Physician's Signature: A/C PMHNP M.D.

ok
09/11/2018

2201

UNIVERSITY OF TEXAS MEDICAL BRANCH

Comprehensive Health Solutions

SICK CALL REQUEST

RECEIVED
SEP 16 2018
BY:

PART A: (To be completed by inmate) Date: 9/16/18

Name: Clint Harrington County #: 64826

Service needed: ☑ Medical ☐ Dental ☐ Mental Health ☐ Other _____

Reason for Health Services Appointment: I would like to speak with Dr. or someone about weining off Methadone a little at a time and come up with a treatment plan. Thankyou! God Bless, Clint Harrington

How long have you had this problem? Hours: _____ Days: 7

PART B: (To be completed by medical personnel- Do not write below this line)

Medical Reply: NSC

L. Marsden, LVN
Medical Staff Member's Signature

9/16/18
Date

2201

UNIVERSITY OF TEXAS MEDICAL BRANCH

Comprehensive Health Solutions

SICK CALL REQUEST

PART A: (To be completed by Inmate)

Name: Clint Harrington Date: 9/19/18

County #: 64826

Service needed: ☒ Medical ☐ Dental ☐ Mental Health ☐ Other

Reason for Health Services Appointment: Shaking, twitching, nauseous
Want to request a medical cell for a few days.
Also need Gulf Bend paperwork so I can get my meds.

How long have you had this problem? Hours: 24 Days: 1

PART B: (To be completed by medical personnel- Do not write below this line)

Medical Reply: NOC

Medical Staff Member's Signature

9/20/18
Date

2201

UNIVERSITY OF TEXAS MEDICAL BRANCH

Comprehensive Health Solutions

SICK CALL REQUEST

RECEIVED
SEP 20 2018
BY:

PART A: (To be completed by inmate) Date: 9/21/18

Name: Clint Harrington County #: 64826

Service needed: ☒ Medical ☐ Dental ☐ Mental Health ☐ Other _____

Reason for Health Services Appointment: anxiety, pain, shaky,

How long have you had this problem? Hours: ~~48~~ 48 Days: 2

PART B: (To be completed by medical personnel- Do not write below this line)

Medical Reply: Gulf Bend appointment 09/20/18

Medical Staff Member's Signature

09/20/18 2325
Date

2201

UNIVERSITY OF TEXAS MEDICAL BRANCH

Comprehensive Health Solutions

SICK CALL REQUEST

PART A: (To be completed by inmate) Date: 9/28/18

Name: Clint Harrington County #: 648726

Service needed: ☑ Medical ☐ Dental ☐ Mental Health ☐ Other _____

Reason for Health Services Appointment: can't sleep; pain, anxiety

How long have you had this problem? Hours: _____ Days: 4

PART B: (To be completed by medical personnel- Do not write below this line)

Medical Reply: Gulf Bend appl. cont 09/29/18

Medical Staff Member's Signature

09/29/18 0145
Date

UNIVERSITY OF TEXAS MEDICAL BRANCH

Comprehensive Health Solutions

SICK CALL REQUEST

PART A: (To be completed by inmate) Date: 9/29/18

Name: Clint Harrington County #: 64826 / 2201

Service needed: ☑ Medical ☐ Dental ☐ Mental Health ☐ Other _____

Reason for Health Services Appointment: Cant sleep, extreme pain & anxiety, Cannot lay down on mat from pain caused from 2 back surgeries, shaking, tremors, restlessness PAIN. Please help me. Thankyou God Bless.

How long have you had this problem? Hours: _____ Days: 5

PART B: (To be completed by medical personnel- Do not write below this line)

Medical Reply: NSC

Medical Staff Member's Signature

9/29/18
Date

UNIVERSITY OF TEXAS MEDICAL BRANCH

Comprehensive Health Solutions

SICK CALL REQUEST

PART A: (To be completed by inmate) Date: 10/2/18

Name: Clint Harrington County #: 64826 / 2201

Service needed: ☑ Medical ☐ Dental ☐ Mental Health ☐ Other _____

Reason for Health Services Appointment: Toe nail [illegible] ripped off. Need bandaids

How long have you had this problem? Hours: 2 Days: _____

PART B: (To be completed by medical personnel- Do not write below this line)

Medical Reply: NSC

Kerry
Medical Staff Member's Signature

10/3/18
Date

202

UNIVERSITY OF TEXAS MEDICAL BRANCH

2201

Comprehensive Health Solutions

SICK CALL REQUEST

RECEIVED
OCT 04 2018

PART A: (To be completed by inmate) Date: 10-03-18

Name: Clinton Harrington County #: 2382

Service needed: X Medical ☐ Dental ☐ Mental Health ☐ Other _____

Reason for Health Services Appointment: I need a bigger shower to shower in because claustrophobia from ptsd causes me to panic uncontrollably from the confined space

How long have you had this problem? Hours: _____ Days: _____

PART B: (To be completed by medical personnel- Do not write below this line)

Medical Reply: Seen at cellside 10/4/18 2140

C Bryan

Medical Staff Member's Signature

10/05/18 0030

Date

180°

UNIVERSITY OF TEXAS MEDICAL BRANCH

Comprehensive Health Solutions

2201

SICK CALL REQUEST

PART A: (To be completed by inmate) Date: 10/3/18

Name: Clint Harrington County #: 648226

Service needed: ☑ Medical ☐ Dental ☐ Mental Health ☐ Other

RECEIVED
OCT 04 2018

Reason for Health Services Appointment: Extreme shaking. Can no longer take care of My OWN ~~Med~~ Needs. Panic attacks, PTSD

How long have you had this problem? Hours: _____ Days: 2

PART B: (To be completed by medical personnel- Do not write below this line)

Medical Reply: MH appt already scheduled

Medical Staff Member's Signature

10/05/18
Date

0025